



**Complete this form only if your qualified health plan is COBRA
Addendum to the Monthly HCTC Registration Form**

The American Recovery and Reinvestment Act of 2009 established a 65% employer-provided COBRA Health Insurance Continuation Premium Subsidy for employees who involuntarily lose their jobs. This new COBRA program is different from the Health Coverage Tax Credit (HCTC) Program. ***If you elect to receive a COBRA Premium Subsidy from your former employer, you are not eligible to receive the HCTC during the same month. If you receive both the COBRA Premium Subsidy and the HCTC during any same month, you will be required to repay the HCTC premium (80% federal portion) to the Internal Revenue Service.***

If your qualified health plan is COBRA, you need to sign and date this form to certify that upon enrolling in the monthly HCTC Program you will not receive an employer-provided COBRA subsidy.

For more information on the COBRA Premium Subsidy program, contact the Department of Labor toll-free at 1-866-444-3272 or visit www.dol.gov/COBRA. If you are unsure whether you receive a COBRA subsidy, contact your former employer.

Sign and date below to have your registration processed.

I certify that I am not enrolled in the COBRA subsidy program. I understand that a knowingly and willfully false statement can result in my disqualification from the monthly HCTC Program and I will have to repay the IRS any credit amount I receive.

Signature

Full Name (Printed)

Social Security Number

Date

Return this form with your Monthly HCTC Registration Form.